

**VIRAL HEMORRHAGIC FEVER
CASE INVESTIGATION FORM**

Outbreak
Case ID:

Health
Facility
Case ID:

Date of Case Report: ____/____/____ (D, M, Yr)

Section 1. Patient Information

Patient's Surname: _____ Other Names: _____ Age: _____ ☐ Years ☐ Months
Gender: ☐ Male ☐ Female Phone Number of Patient/Family Member: _____ Owner of Phone: _____

Status of Patient at Time of This Case Report: ☐ Alive ☐ Dead If dead, Date of Death: ____/____/____ (D, M, Yr)

Permanent Residence:

Head of Household: _____ Village/Town: _____ Parish: _____
Country of Residence: _____ District: _____ Sub-County: _____

Occupation:

☐ Farmer ☐ Butcher ☐ Hunter/trader of game meat ☐ Miner ☐ Religious leader ☐ Housewife ☐ Pupil/student ☐ Child
☐ Businessman/woman; type of business: _____ ☐ Transporter; type of transport: _____
☐ Healthcare worker; position: _____ healthcare facility: _____ ☐ Traditional/spiritual healer
☐ Other; please specify occupation: _____

Location Where Patient Became Ill:

Village/Town: _____ District: _____ Sub-County: _____
GPS Coordinates at House: latitude: _____ longitude: _____
If different from permanent residence, Dates residing at this location: ____/____/____ - ____/____/____ (D, M, Yr)

Section 2. Clinical Signs and Symptoms

Date of Initial Symptom Onset: ____/____/____ (D, M, Yr)

Please tick an answer for **ALL** symptoms indicating if they occurred during **this illness** between symptom onset and case detection:

Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If yes, Temp: ____° C Source: <input type="checkbox"/> Axillary <input type="checkbox"/> Oral <input type="checkbox"/> Rectal	
Vomiting/nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Intense fatigue/general weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Anorexia/loss of appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Difficulty swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Jaundice (yellow eyes/gums/skin)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Conjunctivitis (red eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hiccups	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Pain behind eyes/sensitive to light	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Coma/unconscious	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Confused or disoriented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Unexplained bleeding from any site ☐ Yes ☐ No ☐ Unk

If Yes:

Bleeding of the gums	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Bleeding from injection site	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Nose bleed (epistaxis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Bloody or black stools (melena)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Fresh/red blood in vomit (hematemesis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Digested blood/"coffee grounds" in vomit	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Coughing up blood (hemoptysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Bleeding from vagina, other than menstruation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Bruising of the skin (petechiae/ecchymosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Blood in urine (hematuria)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Other hemorrhagic symptoms ☐ Yes ☐ No ☐ Unk
If yes, please specify: _____

Other non-hemorrhagic clinical symptoms: ☐ Yes ☐ No ☐ Unk
If yes, please specify: _____

Section 3. Hospitalization Information

At the time of this case report, is the patient hospitalized or currently being admitted to the hospital? ☐ Yes ☐ No

If yes, Date of Hospital Admission: ____/____/____ (D, M, Yr) Health Facility Name: _____
Village/Town: _____ District: _____ Sub-County: _____
Is the patient in isolation or currently being placed there? ☐ Yes ☐ No If yes, date of isolation: ____/____/____ (D, M, Yr)

Was the patient hospitalized or did he/she visit a health clinic previously **for this illness**? ☐ Yes ☐ No ☐ Unk

If yes, please complete a line of information for each previous hospitalization:

Dates of Hospitalization	Health Facility Name	Village	District	Was the patient isolated?
____/____/____ - ____/____/____ (D, M, Yr)				<input type="checkbox"/> Yes <input type="checkbox"/> No
____/____/____ - ____/____/____ (D, M, Yr)				<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4. Epidemiological Risk Factors and Exposures

IN THE PAST ONE(1) MONTH PRIOR TO SYMPTOM ONSET:

1. Did the patient have contact with a known or suspect case, or with any sick person **before** becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, please complete one line of information for each sick source case:

Name of Source Case	Relation to Patient	Dates of Exposure (D, M, Yr)	Village	District	Was the person dead or alive ?	Contact Types**
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	

****Contact Types:**
(list all that apply)

- 1 – Touched the body fluids of the case (blood, vomit, saliva, urine, feces)
- 2 – Had direct physical contact with the body of the case (alive or dead)
- 3 – Touched or shared the linens, clothes, or dishes/eating utensils of the case
- 4 – Slept, ate, or spent time in the same household or room as the case

2. Did the patient attend a funeral **before** becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, please complete one line of information for each funeral attended:

Name of Deceased Person	Relation to Patient	Dates of Funeral Attendance (D, M, Yr)	Village	District	Did the patient participate (carry or touch the body)?
		___/___/___ - ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No
		___/___/___ - ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Did the patient travel outside their home or village/town **before** becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, Village: _____ District: _____ Date(s): ___/___/___ - ___/___/___ (D, M, Yr)

4. Was the patient hospitalized or did he/she go to a clinic or visit anyone in the hospital **before** this illness? ☐ Yes ☐ No ☐ Unk

If yes, Patient Visited: _____ Date(s): ___/___/___ - ___/___/___ (D, M, Yr)

Health Facility Name: _____ Village: _____ District: _____

5. Did the patient consult a traditional/spiritual healer **before** becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, Name of Healer: _____ Village: _____ District: _____ Date: ___/___/___ (D, M, Yr)

6. Did the patient have direct contact (hunt, touch, eat) with animals or uncooked meat **before** becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, please tick all that apply:

Animal:

- ☐ Bats or bat feces/urine
- ☐ Primates (monkeys)
- ☐ Rodents or rodent feces/urine
- ☐ Pigs
- ☐ Chickens or wild birds
- ☐ Cows, goats, or sheep
- ☐ Other; specify _____

Status (check one only):

- ☐ Healthy ☐ Sick/Dead
- ☐ Healthy ☐ Sick/Dead
- ☐ Healthy ☐ Sick/Dead
- ☐ Healthy ☐ Sick/Dead
- ☐ Healthy ☐ Sick/Dead
- ☐ Healthy ☐ Sick/Dead
- ☐ Healthy ☐ Sick/Dead

7. Did the patient get bitten by a tick in the past 2 weeks? ☐ Yes ☐ No ☐ Unk

Section 5. Clinical Specimens and Laboratory Testing

Specimen/shipping instructions:

- Label sample with patient name, date of collection, and case ID
- Send sample **cold** with a **cold/ice pack**, and **packaged appropriately**.
- Collect whole blood in a purple top (EDTA) tube – green or red top tubes acceptable if purple not available
- **Preferred sample volume = 4ml** (minimum sample volume = 2ml)

Has this patient had a sample submitted previously? ☐ Yes ☐ No

Sample 1:

Do not complete
UVRI Only

Sample Collection Date: ___/___/___ (D, M, Yr)

Sample Type:

- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Other specimen type, specify: _____

Sample 2:

Do not complete
UVRI Only

Sample Collection Date: ___/___/___ (D, M, Yr)

Sample Type:

- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Other specimen type, specify: _____

Section 6. Case Report Form Completed by:

Name: _____ Phone: _____ E-mail: _____

Position: _____ District: _____ Health Facility: _____

Information provided by: ☐ Patient ☐ Proxy; If proxy, Name: _____ Relation to Patient: _____

Case Name:

Outbreak Case ID:

****If the patient is deceased or has already recovered from illness, please fill out the next section.**

****If the patient is currently admitted to the hospital, leave the next section blank (it will be completed upon discharge)**

Section 7. Patient Outcome Information

Please fill out this section at the time of patient recovery and discharge from the hospital OR at the time of patient death.

Date Outcome Information Completed: ____/____/____ (D, M, Yr)

Final Status of the Patient: ☐ Alive ☐ Dead

Did the patient have signs of unexplained bleeding at any time during their illness? ☐ Yes ☐ No ☐ Unk

If yes, please specify: _____

If the patient has recovered and been discharged from the hospital:

Name of hospital discharged from: _____ District: _____

If the patient was isolated, Date of discharge from the isolation ward: ____/____/____ (D, M, Yr)

Date of discharge from the hospital: ____/____/____ (D, M, Yr)

If the patient is dead:

Date of Death: ____/____/____ (D, M, Yr)

Place of Death: ☐ Community ☐ Hospital: _____ ☐ Other: _____

Village: _____ District: _____ Sub-County: _____

Date of Funeral/Burial: ____/____/____ (D, M, Yr) Funeral conducted by: ☐ Family/community ☐ Outbreak burial team

Place of Funeral/Burial:

Village: _____ District: _____ Sub-County: _____

Please tick an answer for ALL symptoms indicating if they occurred at any time during this illness including during hospitalization:

Fever ☐ Yes ☐ No ☐ Unk

If yes, Temp: ____° C Source: ☐ Axillary ☐ Oral ☐ Rectal

Vomiting/nausea ☐ Yes ☐ No ☐ Unk

Diarrhea ☐ Yes ☐ No ☐ Unk

Intense fatigue/general weakness ☐ Yes ☐ No ☐ Unk

Anorexia/loss of appetite ☐ Yes ☐ No ☐ Unk

Abdominal pain ☐ Yes ☐ No ☐ Unk

Chest pain ☐ Yes ☐ No ☐ Unk

Muscle pain ☐ Yes ☐ No ☐ Unk

Joint pain ☐ Yes ☐ No ☐ Unk

Headache ☐ Yes ☐ No ☐ Unk

Cough ☐ Yes ☐ No ☐ Unk

Difficulty breathing ☐ Yes ☐ No ☐ Unk

Difficulty swallowing ☐ Yes ☐ No ☐ Unk

Sore throat ☐ Yes ☐ No ☐ Unk

Jaundice (yellow eyes/gums/skin) ☐ Yes ☐ No ☐ Unk

Conjunctivitis (red eyes) ☐ Yes ☐ No ☐ Unk

Skin rash ☐ Yes ☐ No ☐ Unk

Hiccups ☐ Yes ☐ No ☐ Unk

Pain behind eyes/sensitive to light ☐ Yes ☐ No ☐ Unk

Coma/unconscious ☐ Yes ☐ No ☐ Unk

Confused or disoriented ☐ Yes ☐ No ☐ Unk

Other non-hemorrhagic clinical symptoms: ☐ Yes ☐ No ☐ Unk

If yes, please specify: _____